

Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form

SECTION 1: AGENCY/POLICY HOLDER INFORMATION *Personnel, payroll, or benefits office completes this section.*

Employing agency		Policyholder name/number Washington State Health Care Authority/123731	Agency/subagency code
Employee's hire date	Employee's gross annual salary	<input type="checkbox"/> Full-time employee <input type="checkbox"/> Part-time employee	Effective date of coverage or change in coverage

SECTION 2: EMPLOYEE INFORMATION *Employee completes this section.*

Social security number	Name (last, first, middle initial)	Date of birth (mm/dd/yyyy)	Employee I.D. number
Street address (include city, state, ZIP Code)			<input type="checkbox"/> Female <input type="checkbox"/> Male
Mailing address (include city, state, ZIP Code)—if different from above		Work phone number	Home phone number
Have you used tobacco products of any kind (including nicotine gum) in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has your spouse/state-registered domestic partner used tobacco products of any kind (including nicotine gum) in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you a retiree returning to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, and you were enrolled in PEBB retiree term life insurance, do you want to keep retiree term life insurance while you're employed? (Cost is \$6.57 per month.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Type of request (check all that apply): <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> New hire (newly eligible) <input type="checkbox"/> Request to cover spouse/state-registered domestic partner* <input type="checkbox"/> Request to cover child(ren) <input type="checkbox"/> Return from leave of absence <input type="checkbox"/> Transfer of coverage from spouse/state-registered domestic partner PEBB life insurance coverage* </div> <div style="width: 50%;"> <input type="checkbox"/> Late entrant (person requesting coverage after initial eligibility) <input type="checkbox"/> Request to remove spouse/state-registered domestic partner from coverage <input type="checkbox"/> Request to remove child(ren) from coverage <input type="checkbox"/> Request to change coverage amounts after initial eligibility <input type="checkbox"/> Request to cancel all life and AD&D insurance coverage (except Basic Life Insurance and Basic AD&D Insurance for employee) </div> </div>			
*within 60 days of marriage or state-registered domestic partnership, or within 31 days of spouse's/state-registered domestic partner's loss of other PEBB life insurance			

SECTION 3: EMPLOYEE LIFE INSURANCE *Employee completes this section. See "Premium Rates" in the Term Life & Accidental Death & Dismemberment Insurance Program booklet to determine your estimated monthly costs.*

	I am requesting the coverage below (enter or check your selections):
Basic Life and Basic Accidental Death & Dismemberment (AD&D) Insurance for Employee Paid by your employer, except if you are on Leave Without Pay.	<input checked="" type="checkbox"/> \$25,000 Basic Life Insurance \$5,000 Basic AD&D Insurance
Supplemental Life Insurance for Employee You may apply for \$10,000 to \$750,000 of Employee Supplemental Life Insurance (in \$10,000 increments). When you are newly eligible for Employee Supplemental Life Insurance: <ul style="list-style-type: none"> If you are less than age 60, you can elect up to \$250,000 without evidence of insurability. If you are age 60 or over, you can elect up to \$100,000 without evidence of insurability. At all other times or to request higher coverage amounts, you must complete a <i>Life Insurance Evidence of Insurability</i> form, to be approved by ReliaStar Life.	A. Total amount desired \$ _____ This is the total amount of coverage you want. B. Current amount \$ _____ If you do not currently have coverage, enter \$0. C. Guaranteed issue amount \$ _____ Newly eligible employees can elect up to \$250,000 (if under age 60) without evidence of insurability, or \$100,000 (if age 60 or over). If you are not a newly eligible employee, enter \$0. D. Amount requiring evidence of insurability \$ _____ (A) - (B) - (C) = (D) <input type="checkbox"/> Cancel this coverage

continued

SECTION 4: SPOUSE/STATE-REGISTERED DOMESTIC PARTNER/DEPENDENT LIFE**INSURANCE** *Employee completes this section.*

I am requesting the coverage below (enter or check your selections):	
Basic Life Insurance for Spouse/State-Registered Domestic Partner and Children You must have Employee Supplemental Life Insurance and Basic Life Insurance for your spouse/state-registered domestic partner to apply for Supplemental Life Insurance for your spouse/state-registered domestic partner.	<input type="checkbox"/> Apply for coverage for my spouse/state-registered domestic partner--\$2,500 life insurance <input type="checkbox"/> Keep coverage for my spouse/state-registered domestic partner--\$2,500 life insurance <input type="checkbox"/> Apply for coverage for my children--\$2,500 life insurance per child <input type="checkbox"/> Keep coverage for my children--\$2,500 life insurance per child <input type="checkbox"/> Cancel spouse/state-registered domestic partner's coverage <input type="checkbox"/> Cancel children's coverage
Supplemental Life Insurance for Spouse/State-Registered Domestic Partner If you have Employee Supplemental Life Insurance and Basic Life Insurance for your spouse/state-registered domestic partner, you may apply for Supplemental Life Insurance for your eligible spouse/state registered domestic partner. You may apply for up to 50% of the amount of your Employee Supplemental Life Insurance, in \$5,000 increments. When you or your spouse/state-registered domestic partner is newly eligible for Supplemental Life Insurance, you can elect up to \$50,000 without evidence of insurability. At all other times or to request higher coverage amounts, you must complete a <i>Life Insurance Evidence of Insurability</i> form for your spouse/state-registered domestic partner, to be approved by ReliaStar Life.	You must have Employee Supplemental Life Insurance and Spouse/State-Registered Domestic Partner Basic Life Insurance to apply for Spouse/State-Registered Domestic Partner Supplemental Life Insurance. A. Total amount desired \$ _____ This is the total amount of coverage you want. This coverage cannot exceed 50% of the Employee Supplemental Life Insurance amount. B. Current amount \$ _____ If you do not currently have coverage, enter \$0. C. Guaranteed issue amount \$ _____ Newly eligible employees or newly eligible spouses/state-registered domestic partners can elect up to \$50,000 (not to exceed 50% of the Employee Supplemental Life Insurance amount) without evidence of insurability. If you are not a newly eligible employee or spouse/partner, enter \$0. D. Amount requiring evidence of insurability \$ _____ (A) - (B) - (C) = (D) <input type="checkbox"/> Cancel this coverage

SECTION 5: SUPPLEMENTAL AD&D INSURANCE *Employee completes this section.*

I am requesting the coverage below (check your selections):	
Supplemental Accidental Death & Dismemberment (AD&D) Insurance for Employee You may apply for \$25,000 to \$250,000 of Employee Supplemental AD&D Insurance (in \$25,000 increments).	<input type="checkbox"/> Employee Supplemental AD&D Insurance in the amount of \$ _____ (in \$25,000 increments, up to \$250,000) <input type="checkbox"/> Cancel this coverage
Supplemental Accidental Death & Dismemberment (AD&D) Insurance for Dependents You must have Employee Supplemental AD&D Insurance to apply for Dependent Supplemental AD&D Insurance.	<input type="checkbox"/> Include this coverage for my dependents. <input type="checkbox"/> Do not include coverage for my dependents. <input type="checkbox"/> Cancel this coverage.

SECTION 6: BENEFICIARIES *Employee completes this section. Attach a list of other beneficiaries if needed (signed and dated).*

Name of beneficiary (last, first, middle initial)	<input checked="" type="checkbox"/> Primary	Relationship to employee	Date of birth (mm/dd/yyyy)
Address (include city, state, ZIP Code)	Benefit %	Social security number	Phone number
Name of beneficiary (last, first, middle initial)	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Relationship to employee	Date of birth (mm/dd/yyyy)
Address (include city, state, ZIP Code)	Benefit %	Social security number	Phone number

SECTION 7: SIGNATURE *Employee completes this section.*

By signing this form, I declare that the information I have provided is true, complete, and correct. **I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.** I authorize my employer to deduct premiums for supplemental coverage from my paycheck. I understand that coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work. I also understand that ReliaStar may require evidence of insurability for coverage to be effective. This form replaces all previous forms and submissions I have made for PEBB life insurance. The information collected about you is confidential. We will not release any information about you without your authorization, except to conduct our business or as required or permitted by law.

Employee's signature _____ Date _____

Return this form to your personnel, payroll, or benefits office.
 Underwritten by ReliaStar Life Insurance Company
 P.O. Box 20, Route 7812, Minneapolis, MN 55440-0020

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